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CHILD HEALTH QUESTIONNAIRE

General Information

Child Name: _____
Date of Birth: _____ Gender Identity: _____
Provincial Health Card #: _____ Province: _____
Expiry Date: _____

Physician and Clinic:
Family Physician: _____ Phone Number: _____
Clinic Name: _____
Clinic Address: _____

Dentist and Clinic:
Family Dentist: _____ Phone Number: _____
Clinic Name: _____
Clinic Address: _____

Health and Developmental History

Describe your child's overall health:

_____
_____
_____

Please check all that apply to your child's health (please describe below):

- ☐ Seasonal allergies
- ☐ Food allergies (see section below titled *Food Restrictions*)
- ☐ Scent sensitivities
- ☐ Asthma or breathing difficulty
- ☐ Chronic ear infections
- ☐ History of seizure from a fever
- ☐ Developmental concerns
- ☐ Concerns during child's pregnancy/labour/delivery

_____
_____
_____
_____

Please note: *If there are more serious or concerning symptoms or conditions present, or if medication is required, separate forms need to be filled out. Please advise us. Thank you.*

Food Restrictions

Does your child have any allergies or sensitivities to food? Yes or No

_____ Allergy / Sensitivity (circle one)

_____ Allergy / Sensitivity (circle one)

_____ Allergy / Sensitivity (circle one)

What will cause a reaction (please check all that apply):

- ☐ Ingestion (your child eats the food)
- ☐ Contact (your child touches the food)
- ☐ Cross-contamination (your child touches a surface that had the food on it)

What is the reaction (please check all that apply):

- ☐ Skin reaction (rash, hives, irritation)
- ☐ Respiratory reaction (difficulty breathing, cough, difficulty swallowing)
- ☐ Gastrointestinal reaction (nausea, cramps, vomiting, diarrhea)
- ☐ Anaphylactic shock (requires medication or Epipen immediately)

Do these allergies or sensitivities require medication? Yes or No

Please list: _____

_____

_____

Are there any foods that you do not want your child to have for reasons other than allergy or sensitivity (for example, religious reasons)? Yes or No

Please list: _____ _____

_____ _____

Vaccinations

Does your child have up-to-date vaccinations? ****Yes** or ***No**

****If yes, please** **fill out below, or attach a copy of your record, or provide the original and we will copy it for our records.***

If no, please note:** **you may be asked to keep your child home in the case of an outbreak of any of the communicable diseases listed below in the daycare facility.

AGE DUE	DATE GIVEN (mm/dd/yy)	VACCINE
2 mos	___/___/____	DTaP-IPV-Hib
2 mos	___/___/____	Pneumococcal Conjugate
4 mos	___/___/____	DTaP-IPV-Hib
4 mos	___/___/____	Pneumococcal Conjugate
6 mos	___/___/____	DTaP-IPV-Hib
12 mos	___/___/____	MMRV
12 mos	___/___/____	Meningococcal C
12 mos	___/___/____	Pneumococcal Conjugate
18 mos	___/___/____	DTaP-IPV-Hib
4-5 years	___/___/____	DTaP-IPV

I hereby certify that my child is free of communicable diseases. Initials _____

By signing below, I certify that all of the above information is true to the best of my knowledge, and I acknowledge receipt of, and agree to, all of the above information.

_____ _____

Parent Signature Date